No. 97-1489

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1997

YOUR HOME VISITING NURSE SERVICES, INC.,
Petitioner,

v.

DONNA E. SHALALA,
Secretary of Health and Human Services,
Respondent.

BRIEF OF *AMICI CURIAE*

The American Hospital Association and The Federation of American Health Systems in Support of Petitioner

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QUESTIONS PRESENTED

1. Whether there is jurisdiction for review of refusals by fiscal intermediaries to reopen Medicare providers' cost reports under 42 U.S.C. § 1395oo, 28 U.S.C. § 1331, 28 U.S.C. § 1361 and/or 5 U.S.C. § 706?

2. Whether 42 C.F.R. § 405.1885(c) is based on a permissible construction of the Medicare statute?

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

TABLE OF AUTHORITIES

Cases

TABLE OF AUTHORITIES

Cases

Statutes

TABLE OF AUTHORITIES

Regulations

Federal Registers

TABLE OF AUTHORITIES

Manuals

Legislative History

Administrative Rulings

Articles

INTEREST OF *AMICI CURIAE*

With the written consents of both parties, which have been filed with the Court, *amici curiae* respectfully submit this brief in support of petitioner, Your Home Visiting Nurse Services, Inc.[1]

Amici curiae are two associations of health care providers. The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. The AHA's mission is to promote high quality health care and health services through leadership and assistance to hospitals in meeting the health care needs of their communities. Its membership includes approximately 5,000 hospitals, health systems, networks and other providers of care. In addition, over 40,000 health care professionals hold individual memberships in the AHA.

The Federation of American Health Systems is the national trade organization representing approximately 1,700 privately owned and managed community hospitals and health care systems. These systems provide comprehensive health care services across the acute and post-acute spectrum. The majority of the freestanding specialty hospitals in the United States are represented by the Federation.

The overwhelming majority of *amici's* members participate as providers of services in the Medicare program. 42 U.S.C. §§ 1395–1395eee. Medicare payments for services rendered to beneficiaries account for approximately forty percent of the revenue of the average member hospital. Hospitals and other health care providers rely on Medicare as a major source of revenue to assure their financial survival. Any substantial loss of Medicare payments can

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[1] Counsel for *amici curiae* listed on the cover authored this brief in whole. No party, other than *amici curiae*, its members or its counsel has made a monetary contribution to the preparation or submission of this brief.

affect a provider's continued ability to provide needed services to Medicare beneficiaries and others in the community. Accordingly, *amici* have an immediate and continuing interest in the integrity of the payment process and in the adequacy of the procedures in place to assure accurate payment determinations.

Amici's members, as participants in Part A of the Medicare program, must submit annual cost reports. The cost report is a complex document that addresses virtually every financial aspect of the operations of a provider. Beginning with the provider's financial books and records, the cost report involves thousands of calculations and the application of volumes of statutes, regulations and policies to the financial activities of the provider over the fiscal year to determine a total annual reimbursement amount. A single cost report adjustment can increase or decrease a provider's Medicare reimbursement by millions of dollars.

To assure the accuracy of the annual payment determination, the Secretary of Health and Human Services ("Secretary") has promulgated a regulation which allows for the reopening of cost reports within three years. 42 C.F.R. § 405.1885. The Secretary, as well as providers, routinely avail themselves of the reopening process to address new, material evidence and to correct clear and obvious errors of fact and law in the payment determination. The Secretary asserts here that the decision of a Medicare fiscal intermediary to deny a provider's request to reopen its cost report may not be reviewed by any individual, agency, administrative tribunal or court. Given the importance of the cost reporting process in the determination of Medicare reimbursement, this delegation of absolute and final discretion to an employee of a private contractor cannot be sustained.

If the Court upholds the Sixth Circuit's decision in *Your Home Visiting Nurse Services, Inc. v. Secretary of Health and Human Services, amici's* members will continue to be

subject to arbitrary decisions by employees of private government contractors on reopening issues that may have substantial financial consequences.

SUMMARY OF ARGUMENT

This case represents another in a long line of attempts by the Secretary to deny providers administrative and judicial review of her Medicare payment determinations. The Secretary interprets the Medicare statute and regulations to preclude any review whatsoever of the determination of a fiscal intermediary to deny a provider's request for reopening of its cost report. Because the jurisdictional statute in question, 42 U.S.C. § 1395oo, clearly and unequivocally authorizes the Provider Reimbursement Review Board ("Board") to review any final intermediary determination that affects a provider's total annual reimbursement, the Secretary's restrictive reading must be rejected.

In addition, the Secretary's reopening process is ripe for abuse, and is fundamentally unfair to Medicare providers. She has delegated blanket discretion to deny reopening requests to private intermediaries that are known to have business interests in conflict with the interests of providers. Through the performance standards imposed on intermediaries, she has created additional incentives against the reopening and correction of erroneous determinations. The potential abuses inherent in the Secretary's reopening scheme do not stop at the intermediary level. The Secretary has demonstrated her willingness to take advantage of the process. She directs intermediaries to reopen cost reports to recoup overpayments, and, at times, directs them *not* to reopen when the correction of errors would result in additional payments to providers. Although the potential for abuse could be mitigated through administrative and judicial review, the Secretary has chosen to deny the very protection Section 1395oo was intended to provide.

Amici urge the Court to reverse the Sixth Circuit's decision in *Your Home*, and to hold that, pursuant to the statutory directive of Section 1395oo, the Board has jurisdiction to review denials of reopening. Alternatively, if the Court finds that the Medicare statute does not confer jurisdiction, the other grants of jurisdiction urged by petitioner should apply to protect providers from the arbitrary denial of payments due under the Medicare statute.

ARGUMENT

I.

MEDICARE PROVIDERS ARE ENTITLED TO ADMINISTRATIVE REVIEW OF REFUSALS TO REOPEN COST REPORTS UNDER THE MEDICARE STATUTE

A. The Secretary's Inequitable Implementation Of The Administrative Review Process.

Congress has established the Provider Reimbursement Review Board as the administrative forum for review of Medicare Part A payment determinations. The governing statute sets forth three conditions that a provider must meet to trigger the Board's jurisdiction. A hearing is available if the provider:

> (1)(A)(i) is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report . . .
>
> * * *
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days. . . .

42 U.S.C. § 1395oo(a) (Supp. 1998). *See also* 42 C.F.R. § 405.1835 (1997).

The Board's jurisdiction will typically be invoked after a provider has filed a cost report with its fiscal intermediary, and the intermediary has reviewed the cost report and has issued a payment determination known as a "Notice of Program Reimbursement." *See* 42 C.F.R. § 405.1803. Under the regulations, a provider may file an appeal with the Board within 180 days after the issuance of the Notice of Program Reimbursement, after the issuance of a revised notice, or within 180 days after certain other determinations. 42 C.F.R. §§ 405.1841(a), 405.1889, 413.30(c), 413.40(e). It is the Secretary's view, however, that an appeal is not available after a request to reopen a prior determination has been denied.

The reopening rule at issue in this case provides that an intermediary's determination may be reopened, so long as a request is made within a three year period. 42 C.F.R. § 405.1885(a). The Provider Reimbursement Manual limits reopening to cases where (1) new and material evidence has been submitted; (2) a clear and obvious error has been made; or (3) a determination is found to be inconsistent with the law, regulations and rulings, or general instructions. Provider Reimbursement Manual (HIM-15) § 2931.2, *reprinted in* 2 Medicare & Medicaid Guide (CCH) ¶ 7739 [hereinafter Manual].[2] Although it makes an exception for providers located in the Ninth Circuit, the Manual states that a refusal by the intermediary to grant a reopening request is not appealable to the Board and cites 42 C.F.R.

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[2] Although it does not have the force and effect of law, the Manual provides guidance regarding the Secretary's interpretation of the law.

§ 405.1885(c) as the authority for this restriction.[3] Manual, *supra* at Appendix A to § 2926, ¶ B.4, *reprinted in* 2 Medicare & Medicaid Guide (CCH) ¶ 7719G. This attempt to limit review of the intermediary's determination must be rejected.

B. The Plain Language And Clear Intent Of Section 1395oo Provide For Review Of Reopening Determinations.

In determining whether the Board has jurisdiction to review an intermediary's denial of reopening, the plain meaning of the statute must control. *Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399, 403 (1988). *See also Bailey v. United States,* 516 U.S. 137, 144-45 (1995) (In interpreting the meaning of a statute, courts must start with the language of the statute.). A decision by the intermediary not to reopen a provider's cost report is unquestionably a "final determination of the . . . fiscal intermediary . . . as to the amount of total program reimbursement due the provider." 42 U.S.C. § 1395oo(a)(1)(A)(i). It is a decision that the provider is not entitled to the reimbursement it seeks, despite the new and material evidence, or the clear error of fact or law, presented by the provider.

The Secretary has conceded in the past, and the Sixth Circuit has agreed, that the decision not to reopen is a final determination, at least in some sense. *Oregon v. Bowen,* 854 F.2d 346, 349 (9th Cir. 1988); *Your Home Visiting Nurse Servs., Inc. v. Secretary of Health and Human Servs.,* 132 F.3d 1135, 1138-39 (6th Cir. 1997) (quoting *Good Samaritan Hosp. Reg'l Med. Ctr. v. Shalala,* 85 F.3d 1057, 1061 (2nd Cir. 1996)). However, the Sixth Circuit reached the erroneous conclusion that this final determination is not

[3]Section 405.1885(c) provides: "Jurisdiction for reopening a determination rests exclusively with that administrative body that rendered the last determination or decision."

related to the amount of program reimbursement due a provider. Where a provider makes a timely and proper request for reopening seeking additional reimbursement, the denial of that reopening is a final determination by the intermediary that the provider's total amount of program reimbursement will not include the additional amount requested. While a denial of reopening may be, as the Sixth Circuit would characterize it, a refusal by the intermediary to revisit the first determination, this does not alter the fact that the intermediary, in denying reopening, has made another determination as to the total amount of the provider's Medicare reimbursement. Indeed, the Ninth Circuit has explicitly recognized that denials of reopening "directly implicate" a provider's amount of total program reimbursement. *Oregon v. Bowen,* 854 F.2d at 349.

In *Bethesda Hospital Association,* the Court was faced with a similarly narrow interpretation of the Board's jurisdiction under Section 1395oo. 485 U.S. 399. In that case, the Secretary attempted to preclude the Board from reviewing a provider's challenge to the validity of a regulation, because the provider failed to obtain the intermediary's determination on the specific cost item at issue. She argued that, because a provider must be "dissatisfied" with a final determination of the intermediary, a provider is entitled only to a hearing on claims actually presented first to the intermediary. The Court properly refused to entertain the Secretary's "strained interpretation," and found that the express language of that section requires nothing more than a provider's dissatisfaction with a final determination of its program reimbursement. *Id.* at 404. Here, the Court should confirm the broad grant of authority to the Board under Section 1395oo and should similarly refuse to narrow the Board's jurisdiction under an equally strained interpretation of the term "final determination."

Although the plain meaning of the statute decides the issue presented here, additional support for a broad reading of Section 1395oo is found in its legislative history.[4] The Court must give effect to the unambiguously expressed intent of Congress. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984). *See also Regions Hosp. v. Shalala*, 118 S. Ct. 909, 915 (1998).

The legislative history of Section 1395oo demonstrates that Congress intended to give providers a definite administrative means by which to appeal an intermediary's final determination. Social Security Amendments of 1972, H.R. Rep. No. 92-231 (1972), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5094. Specifically, when Congress identified the lack of any provision for an appeal by a provider of an intermediary's determination, it established the Board to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items. *Id.; Tallahassee Mem'l Reg'l Med. Ctr. v. Bowen*, 815 F.2d 1435, 1459 (11th Cir. 1987), *cert. denied*, 485 U.S. 1020 (1988). The Sixth Circuit's conclusion that the Board did not have jurisdiction over the intermediary's determination on reopening is directly inconsistent with this legislative history.

Moreover, nothing in the legislative history suggests that Congress intended to prohibit all judicial review of denials of reopening. Neither the Sixth Circuit, nor the other circuit courts that have examined this issue, have identified any legislative history to support the preclusion of Board review

[4] In *Bethesda Hosp. Ass'n*, for example, after the Court examined the express language of Section 1395oo(a) and concluded that the plain language was determinative of the issue, it continued its analysis by examining the "language and design of the statute as a whole." 485 U.S. at 405 (citations omitted).

of denials of reopening.[5] *Good Samaritan Hosp. Reg'l Med. Ctr.*, 85 F.3d 1057 (2nd Cir. 1996); *Athens Community Hosp., Inc. v. Schweiker*, 743 F.2d 1 (D.C. Cir. 1984); *Saint Mary of Nazareth Hosp. Ctr. v. Schweiker*, 741 F.2d 1447 (D.C. Cir. 1984). In the absence of such evidence, the strong presumption that Congress intends judicial review of administrative action must control. *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 676 (1986).

The Court should adopt the sound reasoning of the Ninth Circuit in the *Oregon v. Bowen* case which is in accord with the presumption of judicial review and which found support for Board jurisdiction in the plain meaning and congressional intent of Section 1395oo. If the Board and the courts are prevented from reviewing denials of reopenings, providers that are faced with new and material evidence or clear and obvious errors, will be without recourse, thereby nullifying the very purpose behind Section 1395oo. As the *Oregon v. Bowen* court found, the Secretary's position that the Board does not have jurisdiction over reopening denials would "partly eviscerate[ ] the congressional intent of providing administrative review of a fiscal intermediary's cost determination because [the Secretary's] policy would allow questions of mistaken cost determinations to go unreviewed." 854 F.2d at 350.[6] Finding that there was no reason

[5] In fact, when Congress intends that Board and judicial review of a particular matter should be precluded, it addresses the issue directly through the statute. *E.g.*, 42 U.S.C. § 1395oo(g), prohibiting review of determinations made pursuant to 42 U.S.C. §§ 1395y and 1395ww(d)(7); 42 U.S.C. § 1395yy(e)(8), precluding administrative and judicial review of certain portions of the prospective payment system rates under 42 U.S.C. §§ 1395ff or 1395oo.

[6] The Ninth Circuit found support for the review of reopening determinations in the Medicare statutory provision calling for "retroactive corrective adjustments" to assure that reimbursement is neither inadequate nor excessive. 42 U.S.C. § 1395x(v)(1)(A)(ii). The Ninth Circuit's decision is consistent with this Court's reading of the same

to conclude that Congress intended to prevent review, the court held that the Board had jurisdiction to review a denial of a reopening request. *Id.* at 349-50.

C. Review Of Reopening Denials Is Not Inconsistent With The 180-Day Appeal Limit.

The Sixth Circuit decision in *Your Home* reflects a concern that administrative appeals of reopening denials would somehow frustrate Congress' intent that there be a 180-day time limit by which providers must appeal a final determination. 132 F.3d at 1139. However, permitting an appeal from a reopening denial in no way dissipates the 180-day appeal deadline. A provider would continue to be subject to the 180-day time limit which, pursuant to the statutory language, would run from the most recent determination, *i.e.*, the refusal to reopen.

In fact, the Secretary's regulations recognize that there may be more than one final determination with respect to an annual cost report and, as a result, more than one 180-day appeal period. Providers may request a hearing before the Board within 180 days of each revised determination issued after a reopening. 42 C.F.R. § 405.1889. Similarly, a provider may appeal a denial of an exception to, or exemption from, certain cost limitations. 42 C.F.R. §§ 413.30(c), 413.40(e)(4)-(5). Clearly, the Secretary has not read Section 1395oo to authorize only a single 180-day appeal period.[7]

provision as a "year-end book balancing" requirement. *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 414 (1993). The reopening process allows for retroactive corrective adjustments within three years to assure that final payment is consistent with the Secretary's regulations, thereby assuring the accuracy of the year-end book balancing. The Ninth Circuit correctly concluded that nothing in Section 1395x(v)(1)(A)(ii) suggests nonreviewability.

Moreover, the reopening process itself evidences the Secretary's conclusion that the need for accuracy in the reimbursement determination should override the finality concerns that would be served by imposing a single 180-day appeal limit. In *Regions Hospital*, the Court examined the Secretary's authority to reopen and reaudit cost reports beyond the three year reopening period for purposes of determining base year costs to be used under a new payment methodology. The Secretary took the position that the results of the reaudit would be applied to those cost reporting periods still within the three year reopening window. Neither the Court nor the Secretary was concerned that this approach would undermine the finality concerns underlying the 180-day appeal limit. Instead the Court considered the "three-year reopening window" as the applicable statute of limitations after which a cost report would be considered closed and final. 118 S. Ct. at 913, 915-16, 918.

Arguing that the three year time limit should not prevent the reaudit, the Secretary in the *Regions Hospital* case maintained that the reaudits were necessary "[t]o prevent perpetuation of past mistakes under the new . . . methodology," and to ensure that future payments would be based on an "accurate" determination. *Id.* at 914. The Court was persuaded to permit the reaudit based on the Secretary's

[7] The regulations also permit the Board to extend the 180-day appeal limit for good cause. 42 C.F.R. § 405.1841(b). *See also Western Med. Enters., Inc. v. Heckler*, 783 F.2d 1376, 1379 (9th Cir. 1986), in which the court held that the 180-day time limit does not bar the Secretary from extending the time limit for good cause, because "1395oo is not a narrow jurisdictional statute." That court evaluated the language and history of 1395oo(a) and determined that Congress did not intend to create a "jurisdictional bar" to extension of the time limit by the Board. *Id.*

assertion that Congress, when it changed Medicare payment methodologies, "surely did not want to cement misclassified and nonallowable costs into future reimbursements, thus perpetuating literally million-dollar mistakes." *Id.* at 917. The Secretary's interest in accuracy overrode concerns of finality. It is hypocritical for the Secretary to now argue that providers are time barred from requesting review because the initial 180-day period has run from the intermediary's first determination, when that limit was of no concern to her under the reaudit rule.[8]

The Sixth Circuit also relied on the Court's decision in *Califano v. Sanders,* 430 U.S. 99 (1977), as support for the argument that permitting appeals of reopening denials would frustrate the congressional purpose to impose a 180-day limitation. *Your Home,* 132 F.3d at 1139. The Court in *Sanders* interpreted appeal provisions related to social security disability benefits. In that case, the Court held that judicial review was not available for a denial of a Social Security claimant's request for reopening, in part because it would frustrate the congressional purpose behind a 60-day time limit on requesting judicial review. *Sanders,* 430 U.S. at 108. The Sixth Circuit's reliance on this case, however, is misplaced. Unlike the three year time limit on requests for reopening, the regulation at issue in the *Sanders* case did not provide a time limit on requests for reopening, and indeed, the Social Security claimant had waited seven years to request reopening. Additionally, the claimant in *Sanders* merely sought a redetermination of his case and made no

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[8] Interestingly, when the provider in the *Regions Hospital* case complained that the Secretary's reaudit rules jeopardized finality, the Court consoled the provider by indicating that court review under the Administrative Procedure Act "should protect the Hospital from any future reaudits performed without legitimate reason." 118 S. Ct. at 916 n.2. The petitioner here should similarly be protected from the intermediary's refusals to reopen "without legitimate reason."

allegation of new evidence. Under the applicable Medicare reopening standards, reopenings are limited to cases where there is new and material evidence presented, a clear and obvious error, or a determination is found to be inconsistent with law or regulations. Manual, *supra,* § 2931.2. Finally, and most importantly, the claimant in *Sanders* was able to avail himself of "administrative channels" and have an Administrative Law Judge rule on his reopening request. 430 U.S. at 102-03. Unless the Court overrules the Sixth Circuit decision in this case, however, there is absolutely no review of the intermediary's determination — judicial, administrative or otherwise.

The more recent Supreme Court case of *Interstate Commerce Commission v. Brotherhood of Locomotive Engineers,* 482 U.S. 270 (1987), is more on point here. That case involved a challenge to the Interstate Commerce Commission's refusal to reconsider an order that it had issued. Based on the facts of the case and the failure of the party to allege new evidence or changed circumstances, the Court decided that the denial of the request was not subject to judicial review. However, the Court noted that the result would be different under other circumstances:

> If review of denial to reopen for new evidence or changed circumstances is unavailable, the petitioner will have been deprived of all opportunity for judicial consideration — even on a "clearest abuse of discretion" basis — of facts which, through no fault of his own, the original proceeding did not contain.

Id. at 279. The Court's reasoning in *Locomotive Engineers* is directly applicable here. Under the Medicare rules, providers are entitled to reopening only where new and material evidence exists or where clear and obvious errors of fact or law are present. If the Board's review of a denial of reopening is foreclosed, Medicare providers will be denied the

opportunity for review, even in cases where the intermediary has committed the clearest abuse of discretion with respect to those facts. This result is inconsistent with the clear legislative history of Section 1395oo reflecting congressional intent to *favor* administrative and judicial review. Congress did not intend providers to be subjected to the whims of intermediaries without the opportunity for administrative and judicial review. As the district court for the Northern District of California noted:

> The fiscal intermediaries are merely contractors. They are not officers of the Secretary. Under the Secretary's view, the fiscal intermediary could reject *all* requests to reopen, whether or not the requests had merit, and the Review Board could not intervene. This interpretation contradicts the broad authority Congress granted to the Review Board in 42 U.S.C. § 1395oo(d).

Kootenai Hosp. Dist. v. Bowen, 650 F. Supp. 1513, 1520 (N.D. Cal. 1987) (emphasis in original). The Sixth Circuit's holding that reopening denials are not subject to Board review, therefore, conflicts with the plain meaning and congressional intent of Section 1395oo, and should be reversed.

D. The Secretary's Interpretation Violates Fundamental Principles Of Fairness And Administrative Law.

Although the federal government frequently contracts with private parties for the performance of various functions, the Secretary's delegation of unfettered discretion to an employee of a private contractor appears to be unprecedented.[9] While it is true that the Court in *United States v.*

[9]Generally, where delegation by a federal agency to a private party has been upheld, the agency has retained final reviewing authority. *See R.H. Johnson & Co. v. Sec. & Exch. Comm'n*, 198 F.2d 690 (2nd Cir. 1952) (Commission's delegation to the National Association of Securities Dealers ("NASD") was proper since the Commission reviewed NASD's disciplinary findings), *cert. denied*, 344 U.S. 855 (1952); *Pistachio Group of the Ass'n of Food Indus. v. United States*, 671 F. Supp. 31 (Ct. Int'l Trade 1987) (finding valid an agency's delegation of authority to the New York Federal Reserve Bank ("NY Fed.") because the agency retained authority to review the NY Fed.'s determination of the exchange rate), *aff'd* 685 F. Supp. 848 (Ct. Int'l Trade 1988); *United Black Fund, Inc. v. Hampton*, 352 F. Supp. 898 (D.D.C. 1972) (recognizing as proper the delegation of authority from the agency to the United Way since the agency retained final reviewing authority).

Erika, Inc., 456 U.S. 201 (1982) upheld the delegation of final decision-making authority to Medicare carriers under Part B of the program, that case arose in a completely different context and is easily distinguishable. In *Erika*, the Court precluded judicial review only in the face of a clear congressional directive to limit review of payment determinations made by carriers (the Part B counterpart to Part A intermediaries) involving relatively small individual claims that arise under Part B. The Court was persuaded by extensive legislative history indicating that Congress sought to avoid overloading the courts with "quite minor matters." 456 U.S. at 209 (citing legislative history to the Social Security Amendments of 1972, 118 Cong.Rec. 33992 (1972)).[10]

No such congressional directive exists here. On the contrary, Congress has expressed an unequivocal intent to assure Medicare Part A providers adequate administrative and judicial review of their payment determinations. H.R. Rep. No. 92-231 (1972), *reprinted in* 1972 U.S.C.C.A.N.

[10]It is important to note that Congress itself apparently found the lack of judicial review to be untenable and amended the statutory provision at issue in *Erika* in 1986 to provide for judicial review of the determination of the amount of payment due under Part B, where the amount in controversy exceeds $1,000. 42 U.S.C. § 1395ff(b)(1)(C); Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341(a)(1), 100 Stat. 1874, 2037 (1986).

4989, 5094-95. Nor can the payment disputes that arise in the reopening context be considered "minor matters" that do not justify the consumption of administrative or judicial resources. As the recent case of *Ashland Regional Medical Center v. Shalala* reflects, the payment amounts in dispute under a reopening can be substantial. __ F. Supp. __ (E.D. Pa. 1998), *reprinted in* [1998-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 46,201 (E.D. Pa. 1998). In that case, the reopening denial deprived the provider of more than five million dollars in Medicare reimbursement to which it was clearly entitled. Such substantial Medicare revenue can often mean the difference between the financial survival of a health care provider or the loss of an important health care service to the community.

Your Home also differs substantially from *Erika* in that a carrier hearing was available to the plaintiff in *Erika*, while the petitioner here has been denied any review process whatsoever. The petitioner in *Your Home* is faced with a summary denial issued by an intermediary employee, which merely states that the petitioner did not meet the requirements for reopening. No rationale was provided for rejecting the petitioner's allegations of new and material evidence and factual and legal errors. (Appendix to Petitioner's Petition for Certiorari at 9.) While the petitioner in *Erika* was granted the opportunity through the carrier hearing process to explore the basis for the initial denial and present its arguments, petitioner here had no process in which it could identify even the most egregious kind of bias on the part of the intermediary's employee.

Finally, the decision-making authority delegated to the carrier in *Erika* allowed for considerably less discretion on the part of the private contractor. Although payment amount determinations under Medicare Part B are governed by voluminous and specific rules and regulations, the decision as to whether to reopen a cost report is governed by the

three broad standards set forth in the Manual, *supra,* at § 2931.2. As the scope of discretion is broadened, so also is the possibility of an abuse of discretion heightened.

The dangers inherent in the delegation of broad discretion to private parties are particularly apparent in this case. Because their compensation from Medicare represents a significant source of revenue for intermediaries, it is in their interest to retain their multimillion dollar government contracts. To do so, they must continue to meet performance standards established by the Secretary. 42 U.S.C. § 1395h; 42 C.F.R. §§ 421.120-421.124. *See, e.g.,* 59 *Federal Register* 46258 (1994). This creates strong incentives to deny reopenings based on such inappropriate factors as the time and cost of processing the changes requested by the provider.[11]

Congress has recently recognized the potential for conflicts of interest among Medicare contractors and has acted to mitigate those conflicts in a newly established contracting program. In 1996, Congress enacted the Medicare Integrity Program, establishing a new category of Medicare contractors that will assume many of the functions currently performed by Medicare carriers and intermediaries. The Medicare Integrity contractors must comply with the strict conflict of interest standards generally applicable to federal acquisition and procurement. 42 U.S.C. § 1395ddd(c)(3).

Addressing this requirement in the preamble to the proposed Medicare Integrity Program regulations, the Secretary expressly acknowledged the ever increasing potential for

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[11] These dangers are underscored by the $144 million Blue Cross/Blue Shield of Illinois recently agreed to pay to resolve federal charges of falsifying records to cover up its poor performance as a Medicare contractor. In the Office of Inspector General's News Release dated July 16, 1998, the OIG stated that such misconduct was not unprecedented. *Medicare Carrier Agrees To Pay Record $144 Million Settlement,* OIG News Release (July 16, 1998) <http://www.hhs.gov/progorg/oig/bcbs/hcscse.html>.

actual and apparent conflicts of interest among Medicare contractors:

> In recent years, however, Medicare intermediaries and carriers, like most health insuring organizations, have expanded their business and product lines to become large integrated health care delivery systems .... This creates a conflict of interest when the contractor reviews claims ... and performs other payment safeguard activities for its ... provider's and supplier's competitors.
>
> We have been criticized for the lack of effective mechanisms to mitigate these conflicts of interest. Even when we are assured that proper mechanisms are in place, the appearance of a conflict remains in the eyes of competitors.

63 *Federal Register* 13590, 13592 (1998). The safeguards against conflicts of interest in the Medicare Integrity Program that have been included in the statute and proposed in the regulations were not in place to protect petitioner in this case and will not be available to other providers subject to intermediaries' discretion in the reopening process. Intermediaries will be free to disadvantage their competitors by improperly denying them substantial sums of Medicare reimbursement with impunity.

Even if there is no specific bias, the intermediary's employee could flip a coin to determine whether a reopening would be granted and there would be no review process to identify or remedy the abuse of discretion. While the Secretary, at some point, considered the reopening determination important enough to issue criteria governing the decision, she apparently now is willing to risk the possibility that those criteria may be applied arbitrarily or ignored altogether.

Further, the Secretary's interpretation leads to inconsistency among intermediaries in the application of the standards. This is particularly troublesome for the many multistate health care entities that are *amici's* members. For example, a hospital in Michigan may be granted a reopening and receive payment for a substantial cost, while its sister hospital in Ohio may be denied reopening and payment for the same type of cost, under the same circumstances, by another intermediary, another employee of the same intermediary or even the same employee. Clearly there is no rational basis for this result.

At first glance it may be difficult to understand why the Secretary would choose to allow such potential abuses to go totally unchecked where Section 1395oo provides the obvious means to assure the integrity of the reopening process through the availability of administrative and judicial review. The reason for the Secretary's position becomes clear, however, upon an analysis of the budgetary consequences of her position. Under her view, when a provider has been overpaid she may reopen the cost report determination and recoup the overpayment. If the provider has been underpaid, however, she can either direct the intermediary not to reopen the cost report to pay the additional amount due, or may rely on the intermediary's arbitrary denial of reopening to avoid payment. While this approach may be financially beneficial to the government, it is clearly inconsistent with the Secretary's obligations under the Medicare statute and is patently unfair to providers that have served Medicare beneficiaries with the expectation of payment in accordance with the law.

A comparison of the graduate medical education ("GME") regulations at issue in *Regions Hospital,* with the Secretary's implementation of the disproportionate share hospital ("DSH") adjustment calculation in HCFA Ruling

No. 97-2 (1997),[12] clearly demonstrates the Secretary's willingness to selectively use her skewed process to the detriment of providers.[13]

At issue in *Regions Hospital* was the Secretary's "reaudit" rule, under which she reaudited GME costs incurred in a base year to assure that future GME payments would be accurate. The reaudit rule was designed, in part, to permit recoupment of prior excess reimbursements for years in which cost reports had not become final, *i.e.*, within the three year window. 54 *Federal Register* 40286, 40302 (1989); 118 S. Ct. at 914. As the Court noted, the revised costs determined on reaudit were applied to those cost reporting periods "still open" under Section 405.1885. 118 S. Ct. at 914; 42 C.F.R. § 413.86(e)(1)(iii). The Secretary's authority to make such adjustments in the interest of accuracy and within the three year window was not challenged by the petitioner and was not questioned by the Court.

The concern for accuracy did not prevail, however, under HCFA Ruling No. 97-2. After four courts of appeals struck down an aspect of her calculation of special payments to DSH providers under 42 C.F.R. § 412.106(b)(4), the Secretary issued a ruling acquiescing in the courts' interpretation of the regulation. Application of the courts' rulings would have required additional payments to providers. Notwithstanding the fact that prior determinations made under

[12] *Reprinted in* [1997-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 45,105 (1997). HCFA Ruling No. 97-2 can also be found at its Website, <http://www.hcfa.gov/regs/hr97-2.htm>. HCFA Ruling No. 97-2 has been attached hereto for the Court's reference.

[13] GME and DSH represent special Medicare payments for hospitals that are intended to reimburse them for the costs of operating teaching programs and the high cost of treating unusually large numbers of poor patients, respectively.

the invalid policy were clearly inconsistent with law, and that reopening was therefore required under the Secretary's own criteria, HCFA Ruling No. 97-2 directs intermediaries not to reopen cost reports to pay the additional amounts due. HCFA Ruling No. 97-2 at 2 (Attachment at a-4).

If the Secretary's position is upheld in this case, she will avoid administrative and judicial review when reopening requests are denied based on the directive of HCFA Ruling No. 97-2, even in those four circuits in which the courts of appeals have ruled her prior method of determining DSH payments to be inconsistent with law. Congress could not have intended to insulate such blatant inequities from judicial scrutiny.[14] "Bureaucratic ordering of this sort should not go unchecked by a reviewing court." *Beverly Hosp. v. Bowen,* 872 F.2d 483, 486 (D.C. Cir. 1989).

II.

IF JURISDICTION IS NOT AVAILABLE UNDER SECTION 1395oo, JURISDICTION LIES UNDER 28 U.S.C. § 1331, 28 U.S.C. § 1361 OR 5 U.S.C. § 706

If the Secretary's construction of Section 1395oo is upheld, *amici* support petitioner's assertion that alternative bases for federal court jurisdiction are available to determine whether the intermediary abused its discretion in this case. As noted above, the Court has clearly and consistently recognized the strong presumption that Congress intends judicial review of administrative action. *Michigan Academy,* 476 U.S. at 670; *Abbott Laboratories v. Gardner,* 387 U.S.

[14] The Secretary in her brief before the Sixth Circuit asserts that she could do away with the reopening process altogether. (Respondent's Brief Before the Sixth Circuit at 24 n.9.) While *amici* question her authority to do so without articulating a rational basis for the change, it seems unlikely that she would eliminate a process that is so dramatically slanted in her favor.

136, 140 (1967). The Sixth Circuit in this case relied on the Court's holding in *Califano v. Sanders* to overcome the presumption, suggesting that because the reopening process was created by regulation, rather than by statute, the presumption does not apply. However, the Court's action in *Immigration and Naturalization Serv. v. Doherty* suggests to the contrary. 502 U.S. 314, 322 (1992). In that case, the Court reviewed a decision to deny reopening of deportation proceedings under the abuse of discretion standard even though the reopening process is derived from regulations. Indeed, in numerous cases the Court has indicated that a decision in response to a request to reopen an administrative determination is subject to review, regardless of whether the reopening process is established by statute or regulation. *See Locomotive Eng'rs,* 482 U.S. at 292 n.7 (Stevens, J., concurring), and cases cited therein.

A review of the Court's decisions addressing federal court jurisdiction over claims arising under the Medicare statute indicates that, while the Court will scrupulously hold claimants to the statutorily created avenues to judicial review, where the statute provides no review process, federal question jurisdiction will be available. *Compare Michigan Academy,* 476 U.S. 667 (1986) (Court found jurisdiction under Section 1331) with *Heckler v. Ringer,* 466 U.S. 602 (1984) and *Weinberger v. Salfi,* 422 U.S. 749 (1975) (claimants required to exhaust administrative remedies). Only where there is an unambiguous statement of congressional intent to preclude judicial review altogether, will access to the courts be denied. *Erika,* 456 U.S. 201.

Here there is no evidence of a congressional intent to preclude jurisdiction. Therefore, if the statutorily established avenue to the courts through the Board is foreclosed in this case, jurisdiction to address the serious federal question presented by petitioner must lie under Section 1331. Even if the Court concludes that Section 1395oo does not make

denials of reopenings reviewable, this conclusion alone is not sufficient to support an implication that such denials cannot be reviewed under other grants of jurisdiction. More specific evidence of congressional intent to preclude review would be required to support a jurisdictional bar. *Michigan Academy,* 476 U.S. at 674.

The Secretary argues that 42 U.S.C. § 405(h) prevents any resort to Section 1331 as a source of jurisdiction. In the absence of persuasive evidence of legislative intent to delegate the reopening determination to the unfettered discretion of an intermediary's employee however, the Court should decline to indulge the government's extreme position that Congress intended no review at all of the substantial issues raised by petitioner. *Michigan Academy,* 476 U.S. at 680.[15]

In concluding that jurisdiction is available to review a denial of reopening under both Section 1331 and Section 1361, the District Court of the District of Columbia aptly stated:

> [T]he Secretary cannot relegate providers to a dead-end procedure under the Medicare statute, and then argue that the provider loses because the Medicare statute is the exclusive means of redress. When such bureaucratic red tape strangles a provider's right to judicial review, the Court may invoke its federal question jurisdiction and mandamus power.

Memorial Hosp. v. Sullivan, 779 F. Supp. 1410, 1412 (D.D.C. 1991).

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[15] If the Court concludes that all judicial review is precluded in this case, it will ultimately be faced with the "serious constitutional question" that will arise if Section 405(h) denies a judicial forum for constitutional claims. *Michigan Academy,* 476 U.S. at 681 n.12.

In the event that the Court concludes, however, that review is not available under Section 1331, *amici* join the petitioner in urging the Court to find that the district court may exercise its mandamus power to assure that the Secretary complies with her statutory obligation. In the alternative, *amici* urge the Court to reconsider its decision in *Sanders* and to find the Administrative Procedure Act, 5 U.S.C., chapter 7, as an independent source of jurisdiction.

III.

AS INTERPRETED BY THE SECRETARY, THE REOPENING REGULATION IS INCONSISTENT WITH THE MEDICARE STATUTE

The reopening regulation, set forth at 42 C.F.R. § 405.1885, permits intermediaries to reopen cost reports within a three year period. Section 405.1885(c) states that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." Although this section of the regulation vests discretion with the intermediary to decide whether to reopen, nothing in this provision discusses the *review* of that determination. *Oregon v. Bowen,* 854 F.2d at 349.

Section 405.1885(c) cannot be read implicitly to preclude review of reopening denials. Although the Sixth Circuit found the regulations "silent as to whether a decision not to reopen is subject to review," it deferred to the language in the Manual that states that a refusal by the intermediary to grant a reopening request is not appealable to the Board. *Your Home,* 132 F.3d at 1138; Manual, *supra,* at Appendix A to § 2926, ¶ B.4. However, to the extent the Secretary's interpretation is inconsistent with the statute, it is unlawful. *See, e.g., United States v. Larionoff,* 431 U.S. 864, 872-73 (1977). As discussed above, the plain meaning of the statute, as well as the legislative history, mandate that

the Board be able to review all final determinations of the intermediary as to a provider's total reimbursement. Accordingly, the Manual section precluding review is invalid, and the court's decision in *Your Home* must be reversed. Further, any construction of the regulation itself to prohibit Board review is also invalid because it directly contradicts Section 1395oo.

The Sixth Circuit was persuaded to uphold the Secretary's interpretation of Section 1395oo and the reopening regulation, due in part, to its deference to the Secretary. Deference to the Secretary's interpretation, however, is inappropriate in this case. Courts remain the final authority on issues of statutory construction, and deference must yield to the clear meaning of the statute as revealed by its language, purpose and history. *Chevron,* 467 U.S. at 843 n.9. *See also, Edgewater Hosp., Inc. v. Bowen,* 857 F.2d 1123, 1130 (7th Cir. 1989), *modified,* 866 F.2d 228 (7th Cir. 1989). The statute is clear that the Board has jurisdiction over any final determination of the intermediary regarding a provider's Medicare reimbursement. An interpretation that conflicts with the statute is not entitled to deference. *See Washington Hosp. Ctr. v. Bowen,* 795 F.2d 139, 143 (D.C. Cir. 1986), citing *Chevron,* 467 U.S. at 842 ("If the intent of Congress is clear, that is the end of the matter.").

Even if the Court concludes that Section 1395oo is ambiguous, however, no particular deference to the Secretary is warranted in this case. The traditional deference granted to agency interpretations is based on the Court's respect for the agency's special competence regarding matters within its area of expertise. Procedural issues, however, do not implicate that special competence and therefore are subject to less deference. *See e.g., Nealon v. California Stevedore & Ballast Co.,* 996 F.2d 966, 969 (9th Cir. 1993). Because this issue pertains to an interpretation of the Board's jurisdiction, rather than the complexities of the

Medicare program, this Court need not accord any particular deference to the Secretary's contention that the Board lacks jurisdiction over reopening denials. *Tallahassee Mem'l Reg'l Med. Ctr. v. Bowen,* 815 F.2d at 1458 (Because Section 1395oo is a jurisdictional statute — "a type of statute with which courts are quite familiar" — rather than one involving the Secretary's interpretation of a "technical and complex" area, the court accorded less deference in order to "carefully consider any agency action that potentially has the effect of barring access to the federal courts.") *Cf., Thomas Jefferson Univ. v. Shalala,* 512 U.S. 504, 512 (1994) (Deference warranted because Medicare regulation regarding anti-distribution principle concerned "a complex and highly technical regulatory program" in which the identification and classification of relevant criteria required significant expertise.) (quoting *Pauley v. BethEnergy Mines, Inc.,* 501 U.S. 680, 697 (1991)).

As interpreted by the Secretary in the Manual, *supra,* Section 405.1885(c) is inconsistent with the plain language of the statute. The Court should find that 42 C.F.R. § 405.1885(c) does not preclude the Board's jurisdiction over reopening denials.

CONCLUSION

Amici urge the Court to adopt the reasoning of the Ninth Circuit in *Oregon v. Bowen,* rejecting the Secretary's interpretation of Section 1395oo as inconsistent with the statute and congressional intent. Alternatively, the Court should find jurisdiction in the federal district court to review the denial of petitioner's claim under general federal question

jurisdiction, the court's mandamus powers or under the Administrative Procedure Act.

Dated: July 29, 1998 Respectfully submitted,

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Ruling No. 97-2

Date: February 1997

This Ruling states the policy of the Health Care Financing Administration concerning the determination to change its interpretation of section 1886(d)(5)(F)(vi)(II) of the Social Security Act (the Act) and 42 CFR 412.106(B)(4) to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits. Under the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days for service for patients who were eligible on that day for medical assistance under a State Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.

MEDICARE PROGRAM

Hospital Insurance (Part A).

INTERPRETATION OF MEDICAID DAYS INCLUDED IN THE MEDICARE DISPROPORTIONATE SHARE ADJUSTMENT CALCULATION

PURPOSE: This Ruling announces the Health Care Financing Administration's (HCFA) determination to change its interpretation of section 1886(d)(5)(F)(vi)(II) of the Social Security Act (the Act) and 42 CFR 412.106(B)(4) to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits. Under the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan in

the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.

CITATIONS: Section 1886(d)(5)(F) of the Social Security Act and 42 CFR 412.106(b)(4).

PERTINENT HISTORY: The Medicare disproportionate share hospital (DSH) adjustment calculation, which is set forth in section 1886(d)(5)(F) of the Act, has been the subject of a substantial amount of litigation. The adjustment is calculated by determining a hospital's disproportionate patient percentage which is the sum of two fractions, the Medicare fraction and the Medicaid fraction. In the Medicare fraction, the number of patient days for patients who (for those days) were entitled to both Medicare Part A and Supplemental Security Income (SSI) under Title XVI of the Act is divided by the total number of patient days for patients entitled to Medicare Part A for that same period. The Medicaid fraction consists of the number of patient days for patients who for those days "were eligible for medical assistance under a State plan approved under Title XIX [Medicaid] but who were not entitled to benefits under Medicare Part A" (section 1886(d)(5)(F)(vi)(II) of the Act), divided by the total number of patient days for that same period. The Medicaid fraction is the subject of this ruling.

In implementing the calculation of the Medicaid fraction, HCFA interpreted the statutory language to include as Medicaid patient days only those days for which the hospital received Medicaid payment for inpatient hospital services. This interpretation has been considered by the courts of appeals in four judicial circuits. The initial issue in the litigation was whether HCFA should have counted days for patients who had been found to be Medicaid eligible, but who had exceeded Medicaid coverage limitations on inpatient hospital days of service (and, consequently, no Medicaid payment was made for those days). In later cases,

plaintiffs challenged HCFA's exclusion of any days of inpatient hospital services for patients who met Medicaid eligibility requirements, regardless of the reason for which no Medicaid payment was made. In each of the cases, the court declined to uphold HCFA's interpretation, reasoning that the statutory language "eligible for medical assistance" would include days on which the patient meets Medicaid eligibility criteria regardless of whether payment is made.

Although HCFA believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory language, HCFA recognizes that, as a result of the adverse court rulings, this interpretation is contrary to the applicable law in four judicial circuits.

In order to ensure national uniformity in calculation of DSH adjustments, HCFA has determined that, on a prospective basis, HCFA will count in the Medicaid fraction the number of days of inpatient hospital services for patients eligible for Medicaid on that day, whether or not the hospital received payment for those inpatient hospital services. This would not include days for which no Medicaid payment was made because of the patient's spenddown liability, because an individual was not eligible for Medicaid at that point.

Pursuant to this Ruling, Medicare fiscal intermediaries will determine the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. Days for patients that cannot be verified by State

records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

We will not reopen settled cost reports based on this issue. For hospital cost reports that are settled by fiscal intermediaries on or after the effective date of this ruling, these days may be included. For hospital cost reports which have been settled prior to the effective date of this ruling, but for which the hospital has a jurisdictionally proper appeal pending on this issue pursuant to either 42 CFR 405.1811 or 42 CFR 405.1835, these days may be included for purposes of resolving the appeal.

RULING: For all cost reporting periods beginning on or after February 27, 1997, the Medicare disproportionate share adjustment will be determined by including in the calculation of the Medicaid fraction set forth in section 1886(d)(5)(F)(vi)(II) of the Act the additional days as set forth above.

IV. EFFECTIVE DATE

This Ruling is effective *February 27, 1997.*

Dated: *2/27/97*

Bruce C. Vladeck,
Administrator,